STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
300 W. Preston Street, Suite 202, Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

Office of Preparedness & Response
Sherry Adams, Director
Isaac P. Ajit, Deputy Director

July 13, 2012

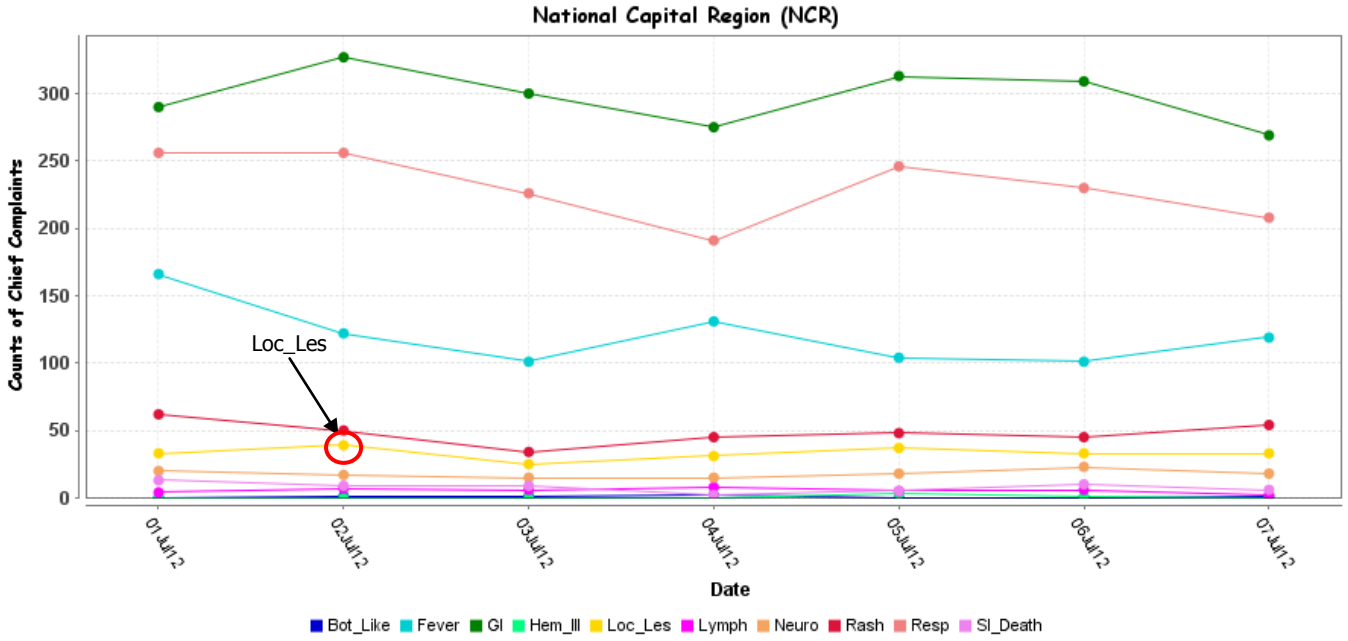
Public Health & Emergency Preparedness Bulletin: # 2012:27
Reporting for the week ending 07/07/12 (MMWR Week #27)

CURRENT HOMELAND SECURITY THREAT LEVELS

National: **No Active Alerts**
Maryland: **Level One (MEMA status)**

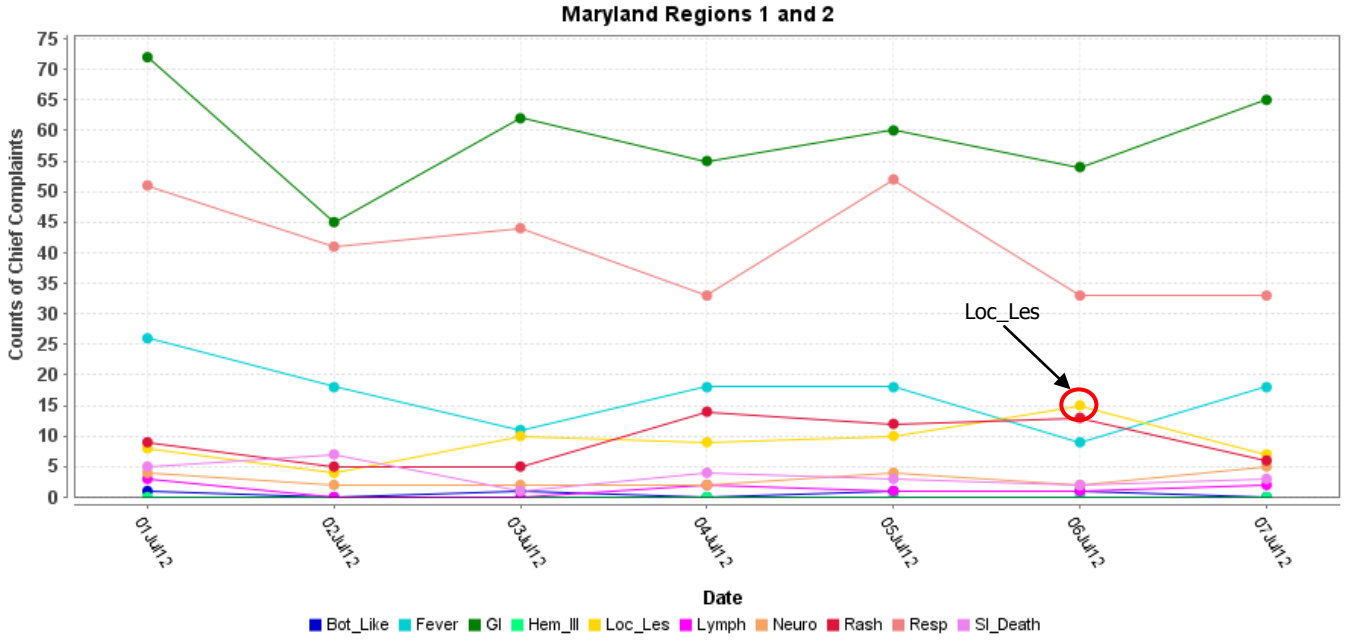
SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.

Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

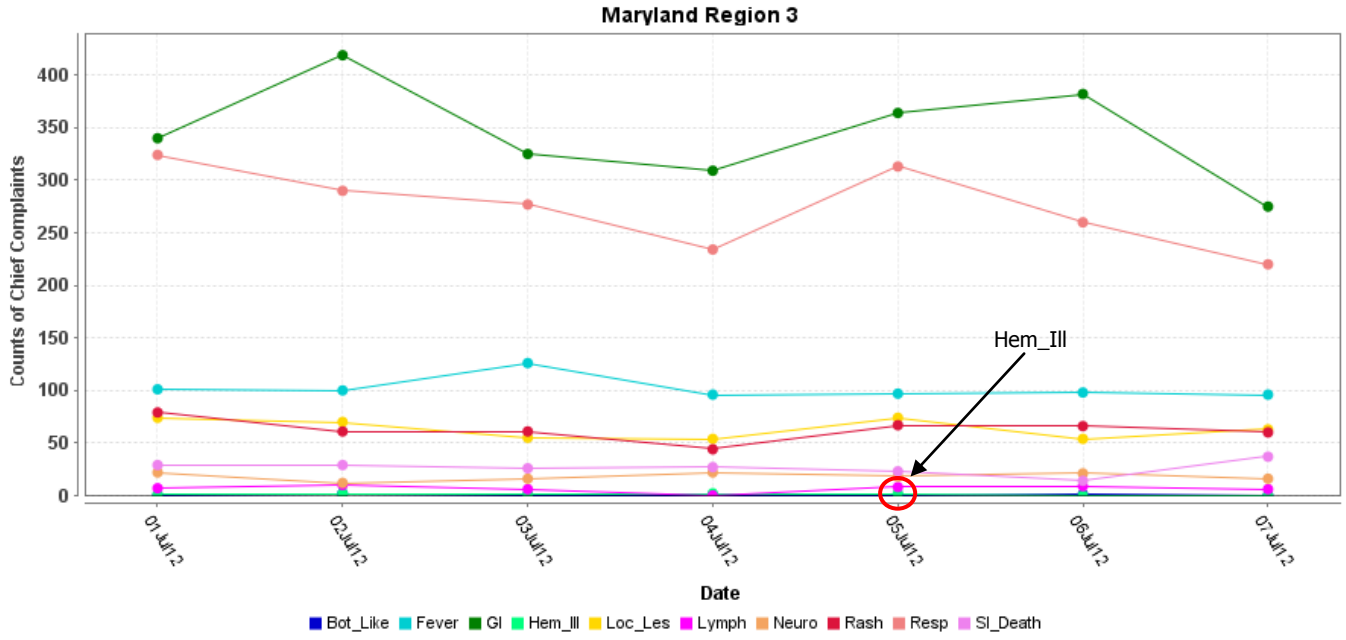


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

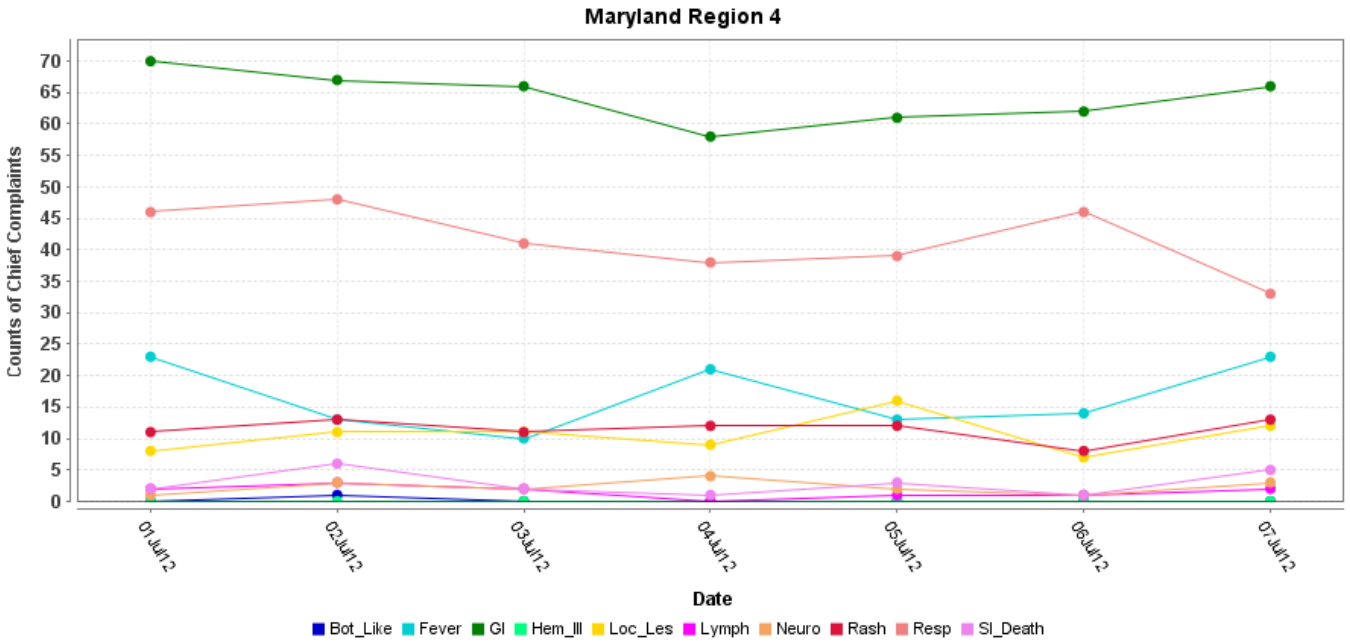
MARYLAND ESSENCE:



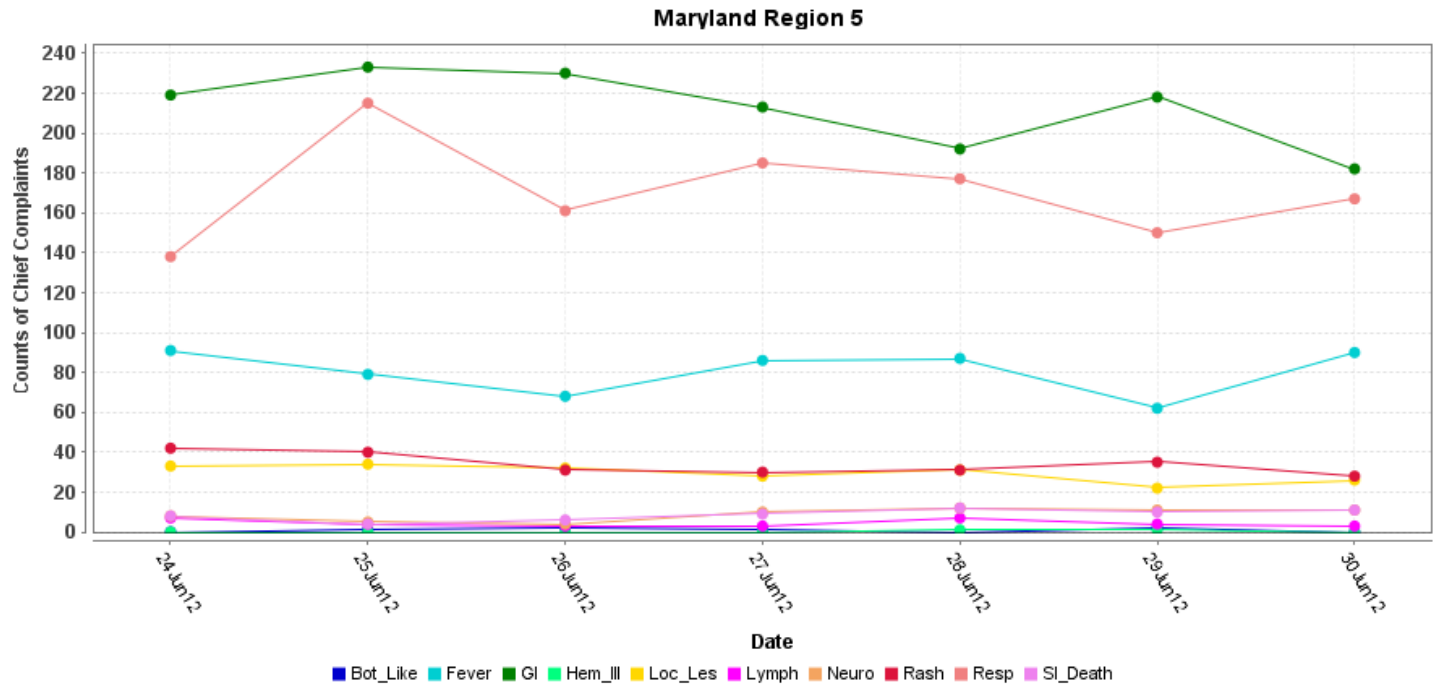
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



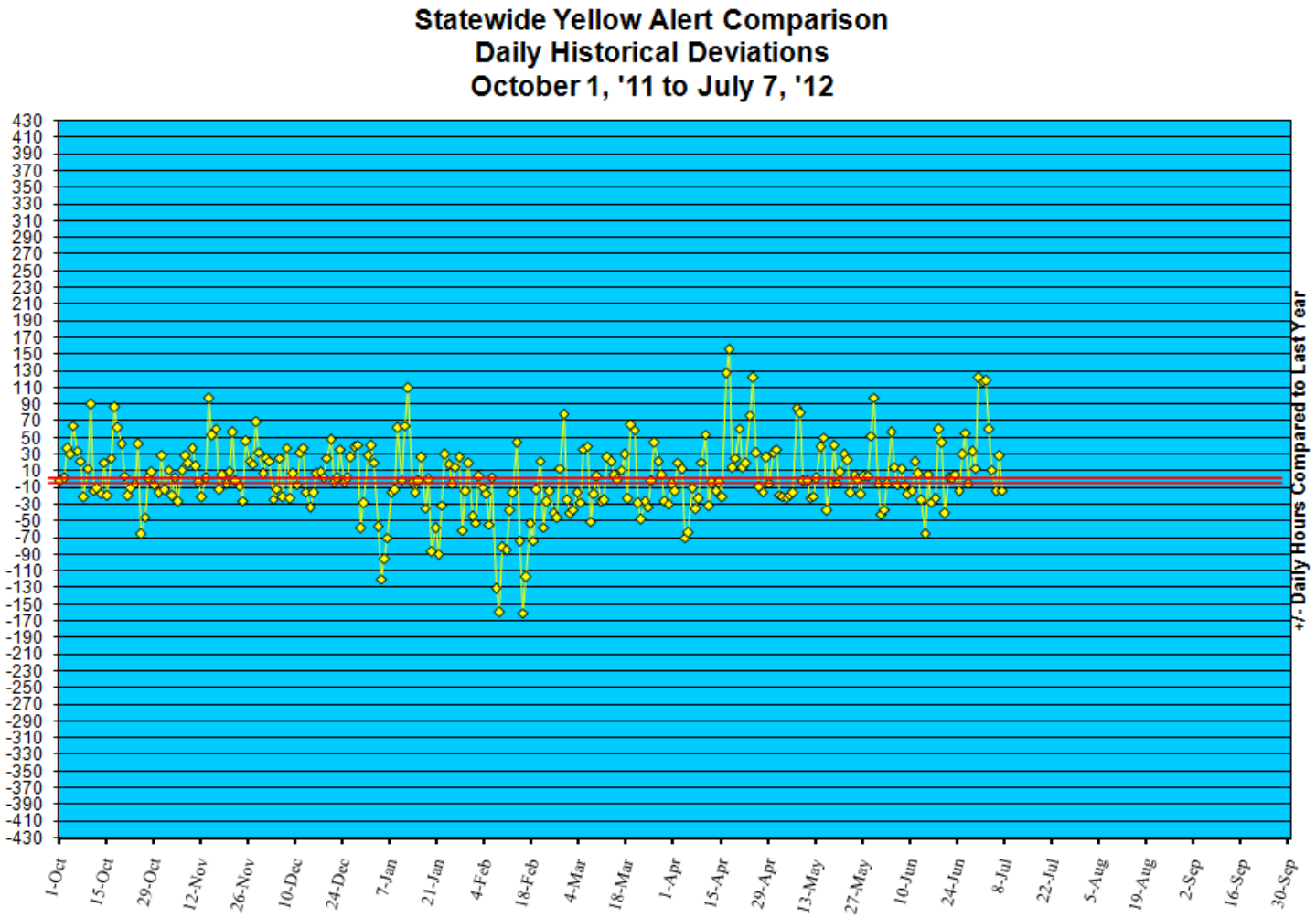
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/11.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in June 2012 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (July 1 – July 7, 2012):	13	0
Prior week (June 24 – June 30, 2012):	15	0
Week#27, 2011 (July 2 – July 8, 2011):	8	0

1 outbreak was reported to DHMH during MMWR week 27 (July 1-7, 2012)

1 Gastroenteritis outbreak
1 outbreak of GASTROENTERITIS associated with a Camp

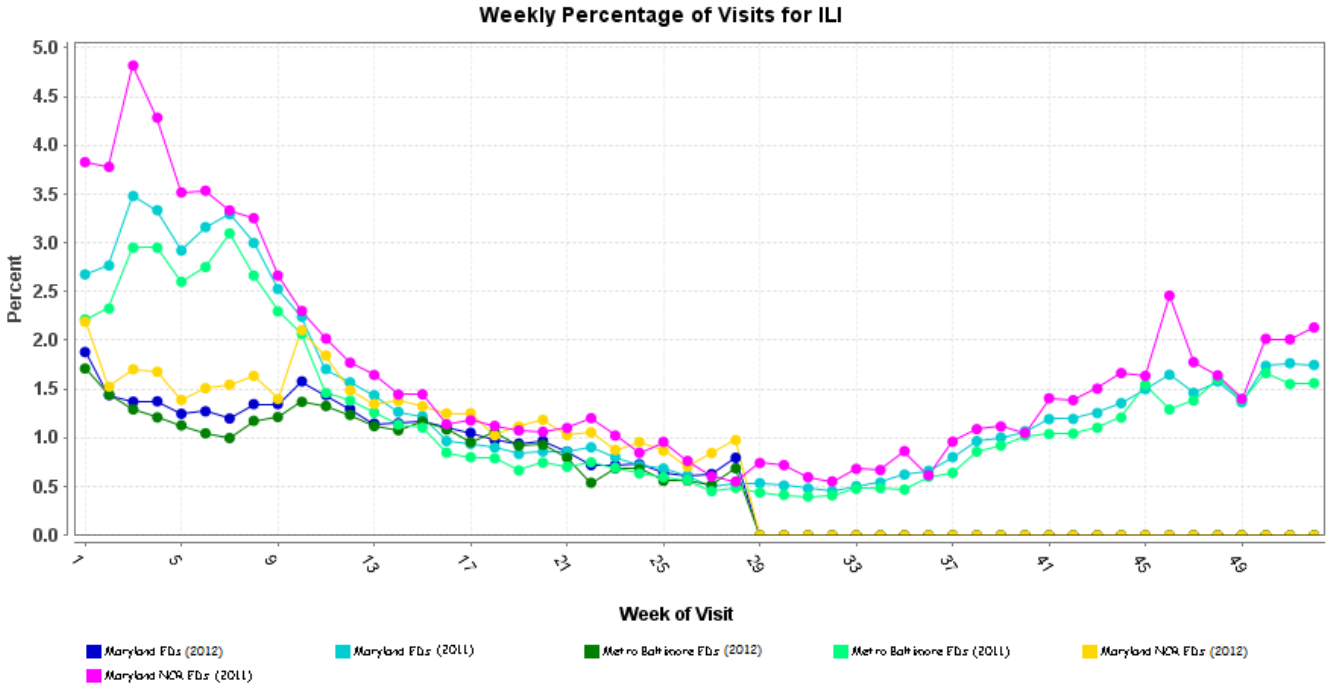
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May.

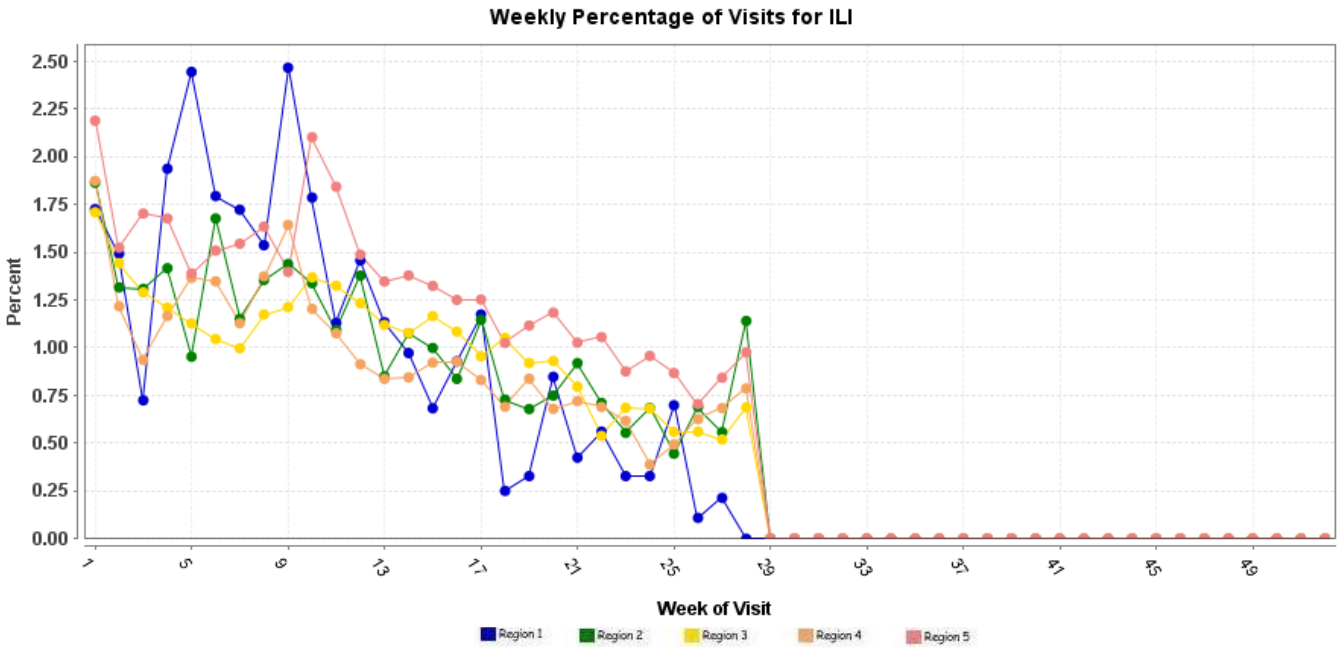
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



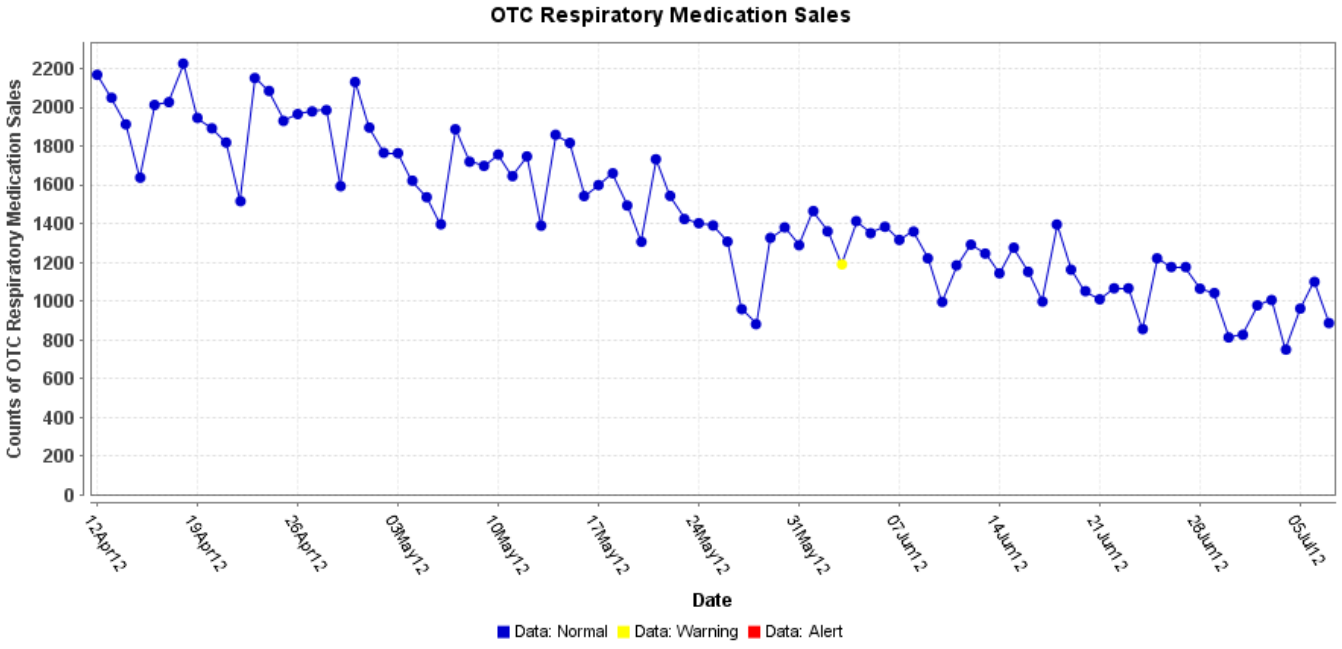
* Includes 2011 and 2012 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2012 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is 3. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

In **Phase 3**, an animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic.

As of July 6, 2012, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 607, of which 358 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

AVIAN INFLUENZA (INDONESIA): 7 July 2012, The Ministry of Health of Indonesia has notified WHO of a new case of a human infection with avian influenza A(H5N1) virus. The case is an 8 year old girl from the province of West Java. She developed fever on 18 June 2012 and then travelled on vacation the following day to Singapore, where she saw a private physician who diagnosed pharyngitis on 20 June. The case returned to Jakarta on 24 June and was still feeling unwell with coughing, decreased appetite, and vomiting. Her family took her for treatment to the local hospital. Her condition deteriorated and she was transferred to intensive care, but died on 3 July. Infection with avian influenza A(H5N1) virus was confirmed by the National Institute of Health Research and Development (NIHRD), Ministry of Health. Epidemiological investigation has been conducted in the case's neighborhood and nearby market, which revealed that the case had contact with poultry when she went to a market with her father to buy live chickens. She was present when the chicken was culled in the designated part of the market. The Ministry of Health in Singapore has been informed about the case under the International Health Regulations. To date, the total number of human influenza A(H5N1) cases in Indonesia is now 190 with 158 fatalities.

NATIONAL DISEASE REPORTS

BOTULISM (OREGON): 3 July 2012, The Oregon State Public Health Lab has confirmed that 3 Central Oregon residents who were hospitalized contracted botulism at a private barbecue, Deschutes County health officials said on Mon 2 Jul 2012. Deschutes County Health Services has conducted an investigation and implicated home canned food as the source of the botulism. Final testing results are pending. No other details were released, though officials told NewsChannel 21 that 2 of the 3 people affected are back at home recovering. "This was an isolated incident and Deschutes County Health Services has notified all involved individuals," a news release stated. "Botulism in not spread person to person, so there is no risk to the general public as a result of these cases." County officials called the incident a good reminder of the importance of following strict hygienic procedures to reduce contamination of foods while canning, as well as obtaining the necessary pressure when canning to effectively destroy bacteria and prevent botulism. (Botulism is listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS

UNDIAGNOSED ILLNESS, FATAL, CHILD (CAMBODIA): 7 July 2012, The Ministry of Health of the Kingdom of Cambodia is conducting active investigation into the cause of a recent undiagnosed syndrome that has caused illness and deaths among children in the country. Preliminary findings of the investigation identified a total of 74 cases who were hospitalized from April to 5 Jul 2012. Of these, 57 cases (including 56 deaths), presented a common syndrome of fever, respiratory, and neurological signs, which is now the focus of the investigation. The majority of the identified cases to date were under 3 years old. Most of them were from the southern and central parts of the country and received treatment at Kantha Bopha Children's hospital, which is a reference pediatric hospital. Despite all efforts, many of the children died within 24 hours of admission. Available samples have been tested at the Institut Pasteur in Cambodia. Although a causative agent remains to be formally identified, all these samples were found negative for H5N1 and other influenza viruses, SARS, and Nipah [virus]. The Ministry of Health was 1st alerted to this by Kantha Bopha Children's Hospital in Phnom Penh, where the majority of the cases were hospitalized. The Ministry of Health notified WHO about this event through the IHR [International Health Regulations] notification mechanism as it met the criteria for notification of any event where the underlying agent or disease or mode of transmission is not formally identified. WHO and partners are assisting the Ministry of Health with this event which focuses on hospitalized cases, early warning surveillance data, laboratory data, and field investigations. While this event is being actively investigated, the government is also looking at other diseases occurring in the country, including dengue, hand, foot and mouth disease, and chikungunya [virus infections]. Parents have been advised to take their children to hospital if they identify any signs of unusual illness. The government is also reinforcing awareness of good hygiene practices to the public, which includes frequent washing of hands. (Emerging Infectious Diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

CHOLERA (CUBA): 7 July 2012, The 1st cholera outbreak in Cuba in a century has left at least 15 dead and sent hundreds to hospitals all but sealed off by security agents bent on keeping a lid on the news, according to reports on Friday 6 Jul 2012. "There are 1000-plus cases" in the south eastern province of Granma, said Yoandris Montoya, who lives in Bayamo, the provincial capital. Security agents have locked down the city's hospital, he added, but staff told him the situation inside is "chaotic". Santiago Marquez, a physician in the neighboring town of Manzanillo, said there is "a lot of panic" in the region because of the lack of official information about the intestinal disease. Cuba's Public Health Ministry, which rarely makes public any information that could give the island a negative image, declared on Tuesday 3 Jul 2012 that it had "controlled" an outbreak of cholera that had killed 3 people and affected 50 others in Granma province. But unofficial reports from the region on Friday 6 Jul 2012, indicated the disease was continuing to spread, with hundreds more suspected cases jamming hospitals in Manzanillo and Bayamo. Montoya said more cases were reported in nearby Niquero and Pilón. As of Friday, 6 Jul 2012, the outbreak had killed at least 15 people and affected hundreds more, Havana independent journalist Calixto R Martinez wrote in a report for the Miami-based blog Cafe Fuerte, or Strong Coffee. Cholera was reported to have been eradicated in Cuba in the late 19th or early 20th century, although it has killed more than 7,400 people and sickened 574,000 in Haiti, just east of Cuba. Scores of Cuban medical personnel work in Haiti. Cuba's once-vaunted public health system has slipped significantly since the end of Moscow's massive subsidies in the early 1990s. During one 24-hour

period in January 2012, 3 flights from Cuba to Toronto arrived with groups of passengers suffering from nausea, vomiting, and fever. Manzanillo human rights activist Tania de la Torre, the wife of Marquez, said residents were boiling their water but could not wash their hands as often as they wished because the city of about 130,000 people has an acute soap shortage. Calls from El Nuevo Herald to the Celia Sánchez Manduley Hospital in Manzanillo, the biggest health institution in the region, were answered by women who said they were not authorized to comment. Martínez told El Nuevo Herald that he had gathered his information from residents and health workers in the region. Some of them called him from public phones because police and state security agents are trying to block reports on the cholera outbreak, he added. A Manzanillo man named Enrique Pineiro told him the death toll had surpassed 16, said Martinez, a member of the independent news agency Hablemos Press. Another man who claimed to have a relative working in a regional hospital put the death toll at 15, he added. The journalist also wrote that Pineiro and a hospital employee reported that doctors are signing death certificates saying that the victims died from "acute respiratory insufficiency" rather than cholera. "We have been forbidden from using the word cholera, and there have been people arrested and detained temporarily in stations of the PNR," the National Revolutionary Police, Pineiro was quoted as saying. The provincial newspaper, La Demajagua, and radio stations have reported nothing on the outbreak. Havana residents said there have been unconfirmed reports of cholera in the capital, especially near Jose Marti International Airport, as well as rumors of an increase in dengue, a disease transmitted by mosquitoes that thrive during the hot and rainy months of summer. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

JAPANESE ENCEPHALITIS (CHINA): 6 July 2012, The Centre for Health Protection today [5 Jul 2012] urged the public to take preventive measures against mosquito-transmitted diseases following a confirmed case of Japanese encephalitis [virus infection] involving a 20 year old woman. She fell ill on 26 Jun [2012] and was admitted to Tuen Mun Hospital's intensive care unit. She is in a serious condition. The woman lives in Tin Shui Wai and recalls being bitten by a mosquito. She has no recent travel history and her home contacts have no symptoms so far. The centre has conducted home visits and surveys. Health talks will be held in Tin Shui Community Centre from 6 - 8 Jul [2012]. This is the 1st case reported to the centre this year. There was one case in 2011. (Viral Encephalitis is listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

ANTHRAX (GERMANY): 5 July 2012, A 3rd case of cutaneous anthrax has been confirmed in a drug user (at the heroin injection site) in Berlin. The patient responded to treatment and as there is no history of travel to Bavaria or of obtaining drugs from the region of the earlier cases, it is now assumed that circulation of contaminated heroin is more widespread than previously thought. (Anthrax is listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

ANTHRAX (RUSSIA): 04 July 2012, It has been established through an investigation by Rosselkhoznadzor [Federal Service for Veterinary and Phytosanitary Surveillance] of Dagestan that 6 residents of Akhvakh district were taken ill with anthrax because of contact with the meat from an infected animal. It should be remembered that on 28 Jun 2012, 6 residents of the settlement of Karat, Akhvakh district of Dagestan, with symptoms of anthrax requested medical aid, and were hospitalized. Among them was a pregnant woman, and she was moved to the hospital of Makhachkala. Today [2 Jul 2012] experts confirmed that the 6 residents of Akhvakh district of Dagestan were ill with the cutaneous form of anthrax. Accordingly the experts of Rosselkhoznadzor carried out a preliminary inspection onsite and established that part of the infected meat was sold to the kindergarten. "Part of the meat [of the infected animal] was sold to the kindergarten but because the refrigerator there was out of order, the manager returned part of the meat to its venders and some was bought by the kindergarten staff. They are among those taken ill." Ruslan Ozdemirov, head of the department of state veterinary surveillance of Rosselkhoznadzor , said to the "Caucasian Knot" correspondent. According to Ozdemirov, protocols were drawn up concerning the woman vendor of the infected meat, which she had sold right from a car without any accompanying documents and the manager of the kindergarten who bought the meat; this was done in the absence of any documents or stamps certifying [prior] veterinary sanitary examination. They may be fined 500 to 1000 rubles [USD 15.5 to 31]. "The experts examined the whole livestock herd where the infected animal had pastured but no other animal with symptoms of anthrax was found. In addition the animals were vaccinated which is mandatory when the disease is detected," Ruslan Ozdemirov said. Gennady Onishenko, head state sanitary doctor of the Russian Federation and head of Rosselkhoznadzor, earlier declared that there was no threat to the people's lives and the situation was under the experts' control, according to RIA "Novosti" reports. On 29 Jun 2012, Magomed Gazimagomedov, head of the Veterinary Committee of Dagestan, reported that according to the data of Anti-contagious [Disease] Service, the condition of all those hospitalized with suspected anthrax was satisfactory. "4 of them are practically ready to leave hospital and the [pregnant] woman who underwent treatment in the Republican Central infectious diseases hospital has already left it," RIA "Dagestan" quotes Gazimagomedov. (Anthrax is listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

SCOMBROID POISONING (ENGLAND): 3 July 2012, Food hygiene experts have intercepted and destroyed 90 kg [200 lb] of tuna loin after a shipment was linked to 4 cases of poisoning. The officers from North East Lincolnshire Council [NELC] acted after receiving a report that crew members of a vessel leaving Immingham had developed symptoms similar to those of histamine poisoning, which can occur if tuna is not kept at the appropriate temperature. A consignment of frozen tuna loin stored at Immingham was identified as being the probable cause. It had originated from Viet Nam and was passing through the area to be supplied to the shipping industry. Further analysis of the consignment revealed that histamine levels were above the legal limits. The symptoms of such poisoning resemble those of an allergic reaction, including nausea, headache, vomiting, diarrhoea, itching, oral burning, red rash, flushing, and hypotension. Symptoms usually appear within 2 hours of ingestion and subside within 16 hours. The crew, who are no longer in the area, are now said to be fit and well. Julie Moody, principal environmental health officer at NELC, said: "Tuna is particularly susceptible to histamine contamination if it is not handled and stored appropriately -- that's why we would strongly urge people to remember to keep fresh tuna chilled and to eat it before the use-by date. "It is likely that the tuna in this case was not kept at appropriate temperatures for the entire length of its journey, allowing the histamine to accumulate. It would be difficult to ascertain at this stage where along the chain the temperature was not controlled properly, but we have acted to ensure that no one else is affected. In these cases we see to it that the product is properly destroyed, so that there is no chance it can somehow re-enter the food chain." Councillor David Bolton, portfolio holder for community safety and neighbourhoods, added: "Even though the tuna was not destined for shops in North East Lincolnshire, this is very important work by the food health team. I am sure that, because of their swift action in removing the tuna from the food chain, they will have prevented numerous further cases of food poisoning." (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

JAPANESE ENCEPHALITIS AND OTHER (INDIA): 1 July 2012, Assam is in deep grip of the killer Japanese encephalitis where the [death] toll has gone up to 20. That too in Sivasagar district alone. Over 100 people from the district have been undergoing treatment in the various hospital. According to reports, cases of acute encephalitis syndrome [AES} are on the rise. The number has shot up to 332 till Saturday. The death toll has touched 50. The worst-hit districts are Kamrup, Sivasagar, Dhubri, Morigaon, Darrang and Nalbari. Doctors blame it all on the halt in fogging due to the floods and rain. They said that during monsoons, people are more prone to diseases. Government efforts are on to keep the situation under control. Although vaccination is said to be an effective way to deal with this menace, the next vaccination program is not known. (Viral Encephalitis is listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail me. If you have information that is pertinent to this notification process, please send it to me to be included in the routine report.

Zachary Faigen, MSPH
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-6745
Fax: 410-333-5000
Email: ZFaigen@dhmh.state.md.us

Anikah H. Salim, MPH, CPH
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-2074
Fax: 410-333-5000
Email: ASalim@dhmh.state.md.us

Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumoccocal meningitis, viral encephailitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephailitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable